

CALIFORNIA MEDICAL ASSOCIATION

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NOTICES AND REPORTS

Prepaid Medical Care Plans Likely to Increase in Importance When "Recession" Comes

According to the American Hospital Association, more indigents and semi-indigents are seeking hospitalization and fewer supposedly solvent persons are paying their hospital bills.

The Institute of Life Insurance reports that the consuming public is now going into debt twice as fast as ever before.

These items published in a recent issue of "Medical Economics" may or may not be harbingers of the much feared "bust"—but no harm would come from assuming that they were. For, no matter what it is called—"bust," "recession," "depression" or "economic adjustment"—the medical profession will feel its effects first. In the average household "time payments" have a higher priority than the doctor's bill. The new car or the quick freezer bought "on time" will be repossessed if not paid for on time—but the doctor's bill can be put aside for better days.

It would not be wise, accordingly, for the physician to disregard any sign pointing to a tightening economic condition. Today, before it is too late, he should look to his credits and check up on his collections with the same care that a bank would give them, under similar circumstances. And perhaps now might be the right time to reappraise the value of medically sponsored prepayment care plans as a protection against loss of income.

In boom times we know that the best fees that the plans can offer *look* modest indeed, when measured against the rich potential of the bulging consumer pocketbook. But when the consumer's cash reserves are gone and he is living from pay check to pay check (as many salaried workers are today), the scheduled fees are not so bad—not so bad from several angles.

In the first place the plans are usually in a better cash position during a period of falling prices than they ever are during a period of inflation. Their ability to pay higher fees is enhanced accordingly.

Another factor to be considered is the rapid in-

crease in medical indigency when depression takes hold. A larger percentage of the physician's patients will be unable to pay for medical care. Membership in prepayment plans may fall off, too, when public income is curtailed—but the more responsible residents of every community *who are members of prepayment plans* will retain their membership despite curtailment of income. Pride, prestige in the community and common sense all act toward the retention of medical care protection in a time of economic uncertainty. If the emergency is severe the physician will find the people who have kept their medical care coverage the most desirable of patients. They will not require fourth notices of balances due, for example.

These factors concern the physician as an individual. There is another that will affect the profession as a whole. It is the effect that a depression will have upon the sponsors of political medical care schemes.

If a larger portion of the population becomes medically indigent, a hue and cry for an emergency control bill can be expected. It might even be attached as a rider to a general relief measure. And, if proposed, it will have an excellent chance of passing. Certainly the indigents would not oppose it. The organized labor group would most certainly support it. As an alternative to serving many without compensation, even some of the physicians might vote for it.

The danger of such emergency legislation is not in its intent, of course, but in its slap-bang construction. Normally it does not receive adequate debate. Under the pressure of need it is usually rushed through without full determination of its fitness to do the job. It frequently contains implications that can be exploited and bugs that cannot be eliminated. Moreover, it is most unlikely that the fees paid to physicians under it would be higher than those paid by existing medically sponsored plans.

Why then invite the risks of such legislation?

Why not, instead, implement the existing plans to act as contractors to the Government for medical care—in times of emergency and all the time?

In California we have the precedent of the Veterans' Administration-C.P.S. Program, under which C.P.S. as a private contractor undertakes to deliver medical care to a mass of the citizenry. A similar program with the proper Government agency could be adapted to cover certified medical indigents. The idea is worth thought and discussion. It would certainly be preferable to contract with the Government than to be dragooned by the Government, in the name of emergency, into a political agreement that might place the freedom of American medicine in jeopardy. Of course a contract assumes the ability of both parties to it to meet its terms. With the understanding and support of the profession, the existing prepayment plans within their areas could deliver medical care as needed—and do it in accordance with the established ethics and practices of the medical profession.

The profession has an opportunity to display real leadership here—but it must act in unity and act positively. The American public will listen to the profession—if it speaks. If it doesn't, the public will listen to the politicians—who, by the way, have largely monopolized the floor to date. But the scales can be redressed very rapidly if the physician will take advantage of his unique position to talk to his patients and friends about the mutually important matter of medical economics.

If an economic emergency develops, it is inevitable that the Government will be called upon to develop ways and means of providing medical care to the people who can no longer pay for it themselves. Let the profession be forehanded then. Let it make a proposal of its own—a proposal that will reflect affirmatively the dignity of a group of freemen discharging its obligations to the Nation.

Such a proposal can be built upon the extended use of the medically sponsored prepayment plans as contractors to the Government.



C.M.A. Statement on Hospitalization

In the minutes of the C.M.A. Council meeting of September 20-21, 1947, reference was made to a statement adopted by the Council following issuance of a pamphlet entitled "Survey of Hospital Facilities in California—Preliminary Report" issued by the Governor's Advisory Council on Hospital Facilities. These minutes appeared on page 341 of the October, 1947, issue of CALIFORNIA MEDICINE.

In response to requests from several sources, there is given below a copy of this statement, which, together with a covering letter, was forwarded to all members of the Governor's Advisory Council on Hospital Facilities. The covering letter went to all members of this Council with the hope expressed that later reports to be issued by the Council might give full weight to the C.M.A. Council statement. This statement follows:

"Statement of the California Medical Association Regarding 'Preliminary Report' of the Governor's Advisory Council on Hospital Facilities"

"The California Medical Association is keenly desirous of increasing the number of hospital beds in the State of California and of developing adequate convalescent and geriatric bed facilities. To that end its members and committees have worked for many years. The Association recognizes that hospitals are an essential part of the care of major illness, notably illness involving surgical procedures. The association does not believe that hospitals were or are designed to furnish medical services. A hospital has no diagnostic or therapeutic facilities to offer; only a duly licensed physician and surgeon has such.

"There recently appeared a 'Preliminary Report

of a Hospital Survey in California' (dated May, 1947, and issued in July of that year). This report contains several statements not consistent with the above. For example, on page 15 appears the following: 'The public is coming to view the hospital . . . as a center from which all types of medical service—preventive, diagnostic and curative—should be made available.' On page 11 the report stresses that 'A hospital is the logical place to refer patients for most types of diagnostic procedures, particularly those of a complicated nature . . . when local conditions are favorable, diagnostic clinics should be established . . .' Again, on page 27 under the heading 'Expansion of Uses of Hospital Diagnostic Facilities' appears the sentence 'Ideally, it would appear that the hospital is the logical place to refer patients for all types of diagnostic procedures.'

"The primary function of the hospital is to furnish bed, board and nursing care to sick persons. Out-patient departments are necessary adjuncts to large teaching institutions, but not essential for the primary functions of the ordinary private hospital. The California Medical Association disapproves the suggestion that ambulatory patients should be referred to hospitals for diagnostic procedures, especially when so many general practitioners, internists, radiologists, pathologists and other physicians maintain well equipped offices in which the vast majority of these procedures may be performed. The diagnosis and treatment of disease is a medical function to be performed by physicians. Since approximately 85 per cent of illness does not require hospitalization, it is obviously not to the interest of the public to have the added expense of a hospital institution when such is unnecessary. The doctor's office is the

logical place to refer patients for diagnostic or therapeutic procedures.

"In summary, the California Medical Association wishes to emphasize that medical procedures performed in hospital buildings are in no wise different from medical procedures performed in medical office buildings. They are medical services, not hospital services. Any statement of policy to the contrary is not founded on fact and does not tend to the public welfare. It is the hope of the C.M.A. that the final report of the Governor's Advisory Council on Hospital Facilities will lead to the provision of needed additional hospital beds in a manner consistent with sound professional practice, and the maintenance of cordial relationships between physicians, hospitals and other elements in the healing arts professions."

Minutes of Executive Committee Meeting

Tentative Draft: Minutes of the 205th Meeting of the Executive Committee, San Francisco, November 9, 1947.

The meeting was called to order by Chairman Sidney J. Shipman at the Saint Francis Hotel, San Francisco, at 11 a.m.

1. Roll Call:

Present were: Chairman Shipman, Council Chairman Edwin L. Bruck, President-Elect E. Vincent Askey, Speaker L. A. Alesen, and by invitation, Councilmen John W. Green, H. Gordon MacLean, Frank A. MacDonald, R. Stanley Kneeshaw, Donald D. Lum. The Executive and Finance Committees of C.P.S., Doctors Donald Cass, H. Randall Madeley, C. L. Cooley, and Robertson Ward, Rt. Rev. Msgr. T. J. O'Dwyer, and Mr. Ransom M. Cook, Mr. William Bowman, Mr. Paolini, Legal Counsel Howard Hassard, C.M.A. Assistant Executive Secretary William P. Wheeler and Miss Harcourt of C.P.S.

Absent: President John W. Cline, Secretary L. Henry Garland (ex officio), Editor Dwight L. Wilbur (ex officio).

Chairman Shipman turned the meeting over to the members of the Executive and Finance Committees of the C.P.S. and Doctor Robertson Ward presented the opening statements and reasons for the meeting. Due to numerous questions C.P.S. felt that it would be beneficial to the membership of the C.M.A. if the over-all financial condition of the C.P.S. were discussed fully.

Rt. Rev. Msgr. O'Dwyer and Mr. Hassard discussed the background and the events leading up to present day activities of C.P.S. and stressed the need of closer cooperation between C.P.S. and the physician membership.

Mr. Bowman distributed financial statements for the six months ended September 30, 1947, and, with assistance by independent accountants of C.P.S., explained each phase of the accounts. After discussion

it was moved by Bruck, seconded by Alesen, and carried, that the complete financial report of C.P.S. be sent with a covering letter of explanation to all county medical societies.

Mr. Ransom M. Cook, assistant secretary and treasurer of C.P.S., discussed the over-all financial position and proposed a plan for placing C.P.S. finances on a current cash basis. He presented the advantages and disadvantages of having a larger surplus in future C.P.S. operations.

Doctor Ward, treasurer, explained the recent actions taken by the Board of Trustees to improve the financial position and operations of C.P.S.

Doctor Cass gave a report on the Joint Control Committee in Southern California, established by C.P.S. and Hospital Service of Southern California.

A general discussion followed, relative to the expansion of C.P.S. and other prepayment plans.

Meeting adjourned at 2:45 p.m.

In Memoriam

ASHKIN, HYMAN. Died May 27, 1947, age 44. Graduate of the Rochester Eclectic Medical College, New York, 1928. Licensed in California in 1938. Doctor Ashkin was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

CARPENTER, HARRY L. Died in Richmond, August 18, 1947, age 72, of coronary thrombosis. Graduate of the College of Physicians and Surgeons of San Francisco, 1904. Licensed in California in 1909. Doctor Carpenter was a retired member of the Contra Costa County Medical Society, the California Medical Association, and an affiliate Fellow of the American Medical Association.

CRISP, NAZARETH JOHN. Died in Benicia, August 26, 1947, age 54, of acute congestive heart failure and polycythemia. Graduate of the College of Medical Evangelists, Loma Linda-Los Angeles, 1925. Licensed in California in 1925. Doctor Crisp was a member of the Solano County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

FALK, CHARLES CLIFFORD, SR. Died in Eureka, November 15, 1947, age 75. Graduate of Cooper Medical College, San Francisco, 1897. Licensed in California in 1898. Doctor Falk was a member of the Humboldt County Medical Society, the California Medical Association, and the American Medical Association.

FINSAND, VICTOR. Died in San Francisco, November 3, 1947, age 59, after a short illness. Graduate of the University of Illinois College of Medicine, Chicago, 1916. Licensed in California in 1922. Doctor Finsand was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

HAUSER, RUPERT VAN ALSTYNE, JR. Died August 8, 1947, age 34, when the airplane he was piloting crashed at Fauts Springs. Graduate Stanford University School of Medicine,